Declaration for Mental Health Treatment

DMHT
Declaration for Mental Health Treatment

A Document To Help People Make Choices About Their Mental Health Treatment

The Tennessee Department of Mental Health and Developmental Disabilities developed this form based on Tennessee Code Annotated Title 33, Chapter 6, Part 10.

Introduction

The Tennessee mental health and developmental disability law gives the right to individuals 16 years of age and over to be involved in decisions about their mental health treatment. The law also recognizes that, at times, some individuals are unable to make treatment decisions. A Declaration for Mental Health Treatment allows persons receiving services to plan ahead; it may also assist service providers in giving appropriate treatment.

The Declaration for Mental Health Treatment form describes what a service recipient wants to occur when he/she receives mental health treatment. It describes mental health services that a service recipient might consider, the conditions under which the Declaration may be acted upon, and directions on how a service recipient can revoke a Declaration.

For example, completion of a Declaration for Mental Health Treatment form allows you to state:
- Conditions or symptoms that might cause the Declaration to be acted upon;
- Medications you are willing to take and medications you are not willing to take;
- Specific instructions for or against electroconvulsive or other convulsive treatment;
- Mental health facilities and mental health providers which you prefer;
- Treatments or actions which you will allow or those which you refuse to permit; and
- Any other matter pertaining to your mental health treatment which you wish to make known.

Instructions

1. Please read the form carefully.

2. Where there are places on the form which ask you to choose between two or more items, you must choose at least one. For example, the following statement from the form requires you to choose one of the options.

   "If I am unable to make mental health treatment decisions, my wishes regarding psychoactive and other medications are as follows:

   You must check one.

   ❑ I do not have a preference regarding medications.
   ❑ I do not consent to the administration of the following medications."

3. Be as specific as possible when identifying your preferences.

4. Be sure to initial and date at the bottom of each page.

5. You must sign the form in front of two adult witnesses who know you.

6. You must discuss the contents of this form with the witnesses required to sign it.

7. It is highly recommended that you discuss the contents of this form with the significant persons in your life and your mental health service providers.

Initial _____ Date _____

Declaration for Mental Health Treatment

for _____

Print Full Name

This Declaration states my wishes for the provision of mental health treatment when I am unable to make informed decisions about my mental health treatment. It is authorized by Tennessee Code Annotated Title 33, Chapter 6, Part 10.

I understand that I may become unable to make infomed decisions about my mental health treatment due to symptoms of a diagnosed mental disorder. These symptoms may include: _____

_____

_____

I recognize that I am able to state my treatment preferences in the following areas: psychoactive and other medications, electroconvulsive and other convulsive therapies, and psychiatric hospitalization for a maximum of fifteen (15) days. This Declaration may include consent to, or refusal to, permit mental health treatment and other instructions and information for mental health service providers.

Psychoactive and Other Medications

If I am unable to make mental health treatment decisions, my wishes regarding psychoactive and other medications are as follows:

You must check one.

- ❑ I do not have a preference regarding medications.
- ❑ I do not consent to the administration of the following medications.

Medication	Reason for Not Consenting

The following medications have worked for me.

Medication	

Conditions or Limitations: _____

_____

_____

Initial _____ Date _____

Admission to and Remaining in a Hospital for Mental Health Treatment*

If I am unable to make informed mental health treatment decisions, my wishes regarding admission to, or remaining in, a hospital are as follows:

You must check one.

- ❏ I do not have a preference regarding admission to a hospital for mental health treatment.
- ❏ I consent to being admitted to a hospital for mental health treatment.
- ❏ I do not consent to voluntary admission to a hospital.

If I am admitted to a hospital for mental health treatment:

You must check one.

- ❏ I consent to remain voluntarily in the hospital for mental health treatment.
- ❏ I do not consent to remain voluntarily in the hospital for mental health treatment.

Conditions or Limitations: _____

_____

_____

_____

_____

**Authorization under a Declaration is limited to 15 days for psychiatric hospitalization.*

Admission to and Continuation of Mental Health Services from Other Facilities

If I am unable to make informed mental health treatment decisions, my wishes about receiving mental health services, or continuation of services, are as follows:

You must check one.

- ❏ I do not have a preference about receiving mental health services from a facility, which is not a hospital.
- ❏ I consent to receiving services from a facility, which is not a hospital.
- ❏ I do not consent to receiving mental health services from a facility, which is not a hospital.

Conditions or Limitations: _____

_____

_____

_____

_____

Initial _____ Date _____

Treatment Provider or Facility

If I am unable to make informed mental health treatment decisions, my wishes regarding treatment providers or treatment facilities are as follows:

Check each that applies.

- ❏ I do not have a preference of providers or treatment facilities.
- ❏ I do not consent to receiving treatment by the listed providers or treatment facilities.
- ❏ I do prefer the following:

Providers

Do not consent	*Prefer*

Treatment Facility

Do not consent	*Prefer*

Conditions or Limitations: _____

_____

_____

Electroconvulsive and Other Convulsive Therapies

If I am unable to make informed mental health treatment decisions, my wishes regarding electroconvulsive and other convulsive therapies are as follows:

You must check one.

- ❏ I do not have a preference regarding electroconvulsive or other convulsive therapies.
- ❏ I do not consent to the administration of electroconvulsive or other convulsive therapies.
- ❏ I consent to electroconvulsive or other convulsive therapies, under the following conditions:

Conditions or Limitations: _____

_____

_____

Initial _____ Date _____

Other Preferences

If I am unable to make informed mental health treatment decisions, my wishes regarding other information or preferences are listed below:

_____

_____

_____

_____

_____

_____

_____

If I am unable to make informed mental health treatment decisions, please inform one of the following:

Name _____ Area Code & Phone Number _____

_____ _____

_____ _____

My Affirmation

I am sixteen (16) years of age or older. I am capable of making informed mental health treatment decisions. I make this Declaration for Mental Health Treatment to be followed, if I become unable to make informed mental health treatment decisions. The determination that I am unable to make an informed decision about my mental health treatment must be made by (1) a court in a conservatorship or guardianship proceeding, or (2) two physicians, or (3) a physician with expertise in psychiatry and a doctoral level psychologist with health service provider designation.

I know that I may cancel this Declaration at any time, orally or in writing, when I am able to make informed treatment decisions.

This Declaration will expire two years from the day it is signed by me and the two witnesses or a shorter period specified by this date:_____.

I affirm that the preferences expressed in this document were made after due consideration and without coercion. I affirm that I have discussed this document with the witnesses.

Print Name _____

Signature _____ Date _____

Address _____

_____

Area Code & Phone Number _____

Date of Birth _____

Initial _____ Date _____

Affirmation of First Witness

I affirm that _____ is personally known to me; that he/she signed this Declaration for Mental Health Treatment in my presence; that he/she talked to me about the document and its contents and the reasons for preparing and wanting the document to be effective. He/she appears to be able to make informed mental health treatment decisions and is not under duress, fraud or undue influence. The Declaration was not signed on the premises of a mental health service provider.

I affirm that I am an adult and that I am not:
- The service recipient's mental health service provider; or
- An employee of the service recipient's mental health service provider; or
- The operator of a mental health facility; or
- An employee of a mental health facility.

YOU MUST CHECK ONE

Yes ❑ No ❑ I am a relative by blood, marriage, or adoption.*

YOU MUST CHECK ONE

Yes ❑ No ❑ I am likely to be entitled to a portion of this person's estate in the event of his/her death.**

Signature _____ Date _____

Address _____

Area Code & Phone Number _____

**Only one of the two witnesses can be a relative by blood, marriage, or adoption.*
***Only one of the two witnesses can be a person likely to benefit from the death of the person completing the Declaration.*

Affirmation of Second Witness

I affirm that _____ is personally known to me; that he/she signed this Declaration for Mental Health Treatment in my presence; that he/she talked to me about the document and its contents and the reasons for preparing and wanting the document to be effective. He/she appears to be able to make informed mental health treatment decisions and is not under duress, fraud or undue influence. The Declaration was not signed on the premises of a mental health service provider.

I affirm that I am an adult and that I am not:
- The service recipient's mental health service provider; or
- An employee of the service recipient's mental health service provider; or
- The operator of a mental health facility; or
- An employee of a mental health facility.

YOU MUST CHECK ONE

Yes ❑ No ❑ I am a relative by blood, marriage, or adoption.*

YOU MUST CHECK ONE

Yes ❑ No ❑ I am likely to be entitled to a portion of this person's estate in the event of his/her death.**

Signature _____ Date _____

Address _____

Area Code & Phone Number _____

**Only one of the two witnesses can be a relative by blood, marriage, or adoption.*
***Only one of the two witnesses can be a person likely to benefit from the death of the person completing the Declaration.*

Initial _____ Date _____

DMHT

Declaration for Mental Health Treatment

Tennessee Department of Mental Health and Developmental Disabilities. Authorization No. 339408, 10,000 copies, November 2001. This document was promulgated at a cost of $0.15 per copy.

Additional copies of this form may be obtained from the Tennessee Department of Mental Health and Developmental Disabilities' website at http://www.state.tn.us/mental/.

For additional information contact the Tennessee Department of Mental Health and Developmental Disabilities' Office of Consumer Affairs 1-800-560-5767. Document number MHDD-5067.